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Nos. 93-1408, 93-1414, and 93-1415

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
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HOSPITAL ASSOCIATION OF NEW YORK STATE,
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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA) preempts the New York all-payor hospital reimbursement system to the extent that the system provides, irrespective of ERISA status, one set of rates for patients covered by Medicaid, Blue Cross plans and health maintenance organizations ("HMOs") and another set of rates for patients covered by other third-party payors, including commercial insurers, because the different rates may affect ERISA plans' costs or their choice of coverage.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Second Circuit, which is contained in the separately-bound joint Appendix to the Petition at pages A-1 to A-2. Because of the numerosity of the parties, the list will not be reproduced herein.

In accordance with Supreme Court Rule 29.1, Petitioner Hospital Association of New York State states that it does not have a corporate parent or subsidiaries, other than wholly-owned subsidiaries.

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OPINIONS BELOW

The amended opinion of the United States Court of Appeals for the Second Circuit is reported at 14 F.3d 708. It is reprinted in the separately-bound joint Appendix to the Petition at A-1 to A-34. The opinion of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996. It is reprinted in the separately-bound joint Appendix to the Petition at A-63 to A-90.

JURISDICTION

The judgment of the court of appeals was initially entered on October 25, 1993. On January 12, 1994, the court of appeals granted a petition for rehearing, and on January 14, 1994, the court entered a new judgment and amended opinion. The petition for a writ of certiorari was filed on March 9, 1994, and was granted on October 7, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

The relevant statutory provisions are:

(a) ERISA § 514(a) (codified at 29 U.S.C. § 1144(a) (1988)), which provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) ERISA § 514(b)(2)(A) (codified at 29 U.S.C. § 1144(b)(2)(A) (1988)), which provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to ex-

empt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(c) N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993), a copy of which is set forth in the joint Appendix to the Petition at A-101 to A-102.

(d) N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993), a copy of which is set forth in the joint Appendix to the Petition at A-102 to A-103.

STATEMENT

Pursuant to its constitutional mandate to protect and promote the health of its inhabitants (N.Y. Const. art. XVII, § 3), New York has long engaged in the comprehensive regulation of the activities of hospitals, including the rates they charge. While the methodologies for setting in-patient hospital rates have evolved to reflect changes in the industry, the objectives have remained constant: to provide all patients with access to the highest quality of care; to ensure that hospitals receive adequate revenue; to contain the costs of hospital care; and to distribute the costs of hospital care equitably among all payors. The question presented here is whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, preempts efforts by New York to meet these objectives by setting different rates for different categories of patients. The court of appeals held that the New York law was preempted because the different rates could substantially increase the costs to ERISA plans or affect the choices made by ERISA plans about coverage for hospital services.

1. *Hospital Reimbursement Methodology In New York.*

The present hospital reimbursement system in New York is a case-based system. Like Medicare and healthcare systems in many other States, it directs hospitals to charge fixed rates for each patient treated, based upon the

patient's diagnosis rather than the actual cost of the services performed. Under this system, each medical diagnosis falls into one of 794 categories, known as diagnostic related groups ("DRGs"). J.A. 152. Each DRG, in turn, is assigned a specified rate, which is generally based on the expected average cost incurred by all hospitals to treat a patient in that DRG. J.A. 152. Because hospitals receive predetermined amounts for each service, regardless of the actual resources expended to treat a patient, the DRG system has a built-in incentive for hospitals to employ their resources efficiently and to contain costs.

While the 794 DRG categories are fixed across the State, the actual case-based rates for each DRG category vary among all hospitals in the State. Each of the separate 794 DRGs for each hospital is based on myriad components, many of which are hospital-specific. These components include the hospital's historical operating costs, the total number of patients that the hospital treats annually, the total number of Medicare patients that the hospital treats annually, whether the hospital is a teaching facility, and whether the hospital is located in New York City or upstate, or in a rural community. J.A. 250-53.

2. a. *The 13 Percent Differential.*

Once the case-based rates are calculated for a particular hospital, Section 2807-c(1)(a) of the New York Public Health Law requires that the hospital bill its patients covered by Medicaid, Blue Cross plans, and certain Health Maintenance Organizations (HMOs) at that basic rate. *See* Pet. App. A-101 to A-102. Section 2807-c(1)(b), in contrast, requires the hospital to bill other patients at a rate that is 113% of the basic rate. *See* Pet. App. A-102 to A-103. The patients subject to the higher rate include patients covered by commercial insurance, as well as those covered by workers' compensation, the volunteer firefighters' benefit system, the volunteer ambulance workers' system, the "no-fault" motor vehicle insurance system, and

self-insured funds. *See* Pet. App. A-102 to A-103.[1] It is this 13% differential that the commercial insurers have challenged in this action.[2]

While this action represents the first time that any commercial insurer has challenged the differential, the differential is a long-standing part of the hospital reimbursement system in New York. Differentials between the rates charged to patients covered by Blue Cross and by Medicaid and the rates charged to other patients have existed for years in New York (J.A. 148), first as a matter of practice, and then as a matter of law. J.A. 148-50. The difference in rates charged to Medicaid patients and insureds of Blue Cross, as opposed to other patients, takes into account the special burdens that these payors have assumed in pursuit of the State's efforts to assure affordable health care for all its residents.

The burdens historically assumed by Blue Cross are numerous and important. Unlike commercial insurers,

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[1] Patients not covered by either subsection (a) or subsection (b) make payments "on the basis of the hospital's charges," N.Y. Pub. Health Law § 2807-c(1)(c); *see* Pet. App. A-103, subject to a maximum of 120% of the rate set forth in subsection (b). *Id.*

[2] Some respondents (the commercial insurers) also challenged a temporary 11% assessment under N.Y. Pub. Health Law § 2807-c(11)(i), imposed only on hospital bills of patients covered by commercial insurance, and not other types of third-party payors. This 11% assessment became effective in April 1992 and expired in March 1993. Unlike revenue from the 13% differential, the revenue generated by the 11% assessment was ultimately paid to the State, not to hospitals.

Unlike the commercial insurers, the HMO respondents took no position on the 13% differential. They have challenged, however, an assessment of up to 9% under N.Y. Pub. Health Law § 2807-c(2-a)(a)-(e), applying to hospital bills for patients covered by certain HMOs that fail to enroll a certain number of Medicaid recipients. Despite differences in the operation and purposes of the three statutes, the courts below have treated the 13% differential and the 9% and 11% assessments identically under their ERISA preemption analyses. In this brief, we address only the 13% differential.

Blue Cross plans have traditionally offered insurance to sick or elderly individuals who were unable to obtain insurance from other sources (open enrollment), charged premiums to subscribers based on the overall experience of the community instead of a particular subscriber's own medical experience (community rating), and provided advance payments to hospitals. J.A. 161-68. These policies, among other things, helped to reduce the number of charitable care patients that hospitals must serve. The State has recognized that, absent some special considerations for undertaking these public burdens, Blue Cross plans could not effectively compete for the business of healthier segments of the population. That inability, in turn, would threaten the viability of the Blue Cross plans, the availability of insurance for high-risk persons, and ultimately the stability of hospitals that depend upon predictable and adequate revenues. J.A. 163.

Prior to 1978, the rates paid to hospitals by Blue Cross were substantially lower than the rates paid by other payors. As the disparity in the rates reached 36%, the State in 1978 enacted legislation that temporarily froze hospital rates until the State could study fairer methods for all payors, including commercial insurers. J.A. 243. In 1982, following an extensive review of hospital financing, the State enacted its first comprehensive hospital reimbursement statute, called the New York Prospective Hospital Reimbursement Methodology ("NYPHRM I"), to take effect in 1983. The overall goal of NYPHRM I was to establish a fully integrated reimbursement system, encompassing all classes of payors, that would provide adequate revenue to hospitals while promoting efficient use of resources and widespread access to health care. J.A. 150. Integral to this all-payor system was a statutory limitation on the differential in hospital rates, which was set between 12% and 15%. J.A. 243-44.

Recognizing the effectiveness of that type of comprehensive health care regulation, the Secretary of Health and Human Services in 1982, pursuant to Congress' authoriza-

tion, elected to reimburse hospitals for services to Medicare patients under rates set by NYPHRM I. 42 U.S.C. § 1395b-1. As a result, the rates charged to Medicare, which otherwise would have been set by federal law, were set, subject to an upper limit, by New York law.[3] That same year, Congress substantially reformed the Medicare system for the rest of the country. New York was exempted, however, due to participation by Medicare in NYPHRM I.[4]

In 1985, NYPHRM I expired and NYPHRM II was enacted, covering in-patient hospital reimbursement from 1986 through 1987. NYPHRM II limited the disparity for in-patient hospital rates among payors to no more than 12%. J.A. 246. In 1988, the State enacted NYPHRM III, which governed hospital reimbursement from 1988 through 1990. NYPHRM III changed the all-payor hospital reimbursement methodology to a DRG-based system, with a 13% differential between the rates for patients covered by Medicaid, Blue Cross, and HMOs and the rates for patients covered by other third-party payors. J.A. 248. In 1990 the State enacted NYPHRM IV, which continued the all-payor DRG system and the 13% differential.[5]

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[3] Pursuant to NYPHRM I, the rates charged to Medicare were the same discounted rates charged to Medicaid and Blue Cross patients, which were lower than the rates charged to patients covered by commercial insurance. N.Y. Pub. Health Law § 2808-c(1).

[4] NYPHRM I was challenged on ERISA preemption grounds in *Rebaldo v. Cuomo*, in which the Second Circuit held that the right of the State to set rates for participants in ERISA plans, along with all other patients, was not preempted. 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). In its *Travelers* decision, the Second Circuit held that the reasoning in *Rebaldo* was no longer valid, after the decision of this Court in *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). See Pet. App. A-21.

[5] After the filing of the lawsuit, New York enacted NYPHRM V, which again continued the 13% differential for all payors (except workers' compensation).

b. *The 13 Percent Differential and ERISA Plans.*

Members of "employee welfare benefit plans" under ERISA are among the patients receiving in-hospital care in New York. "An 'employee welfare benefit plan' includes any program that provides benefits for contingencies such as illness, accident, disability, death, or unemployment." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 n.5 (1983) (citing 29 U.S.C. § 1002(1)).

The 13% differential operates without regard to whether a patient is or is not a participant in an ERISA plan. As the terms of the law make clear, application of the 13% differential depends entirely upon the form of coverage that the patient carries. The effect of the law is thus exactly the same for patients who purchase insurance directly as for patients who are members of ERISA plans. For example, a patient covered by Blue Cross will be billed the prescribed rate under Section 2807-c(1)(a) whether or not that patient participates in an ERISA plan. Similarly, under Section 2807-c(1)(b), a hospital will bill 113% of the DRG rate to patients covered under other arrangements, including commercial insurance, whether or not the patient is a participant in an ERISA plan.

Like other consumers, ERISA plans may choose among different forms of coverage for their members. For example, an ERISA plan may decide to obtain coverage from Blue Cross (which pays hospitals at the DRG rate); to obtain coverage from commercial insurers (which pay at 113% of the DRG rate); to obtain coverage by an HMO (which pays either at the DRG rate or at a negotiated rate)[6]; or to self-insure.[7] If an ERISA plan elects

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[6] Under New York law, HMOs are the only payors permitted to negotiate their payments to hospitals. N.Y. Pub. Health Law § 2807-c(2)(b)(i).

[7] A plan need not elect a single form of coverage for all employees. Indeed, it is typical for larger employers, as part of their plans, to offer employees the choice of HMO, commercial or Blue Cross coverage, each with its own set of benefits and costs.

to self-insure, it may either pay the hospital directly (at 113% of the DRG rate) or choose to pay indirectly, *e.g.*, issue a two-party check with the patient and the hospital as payees. In the latter case, the plan pays the hospital's statutorily-capped charges, which may be higher or lower than the case-based rate. N.Y. Pub. Health Law § 2807-c(1)(c).[8]

3. ***The Proceedings Below.***

a. Respondent The Travelers Insurance Company initially commenced a declaratory judgment action against the State petitioners seeking, *inter alia*, to invalidate the 13% differential, as applied to commercial insurers, on ERISA preemption grounds. This suit was followed by a second action, brought by Respondent Health Insurance Association of America and other insurance trade associations and individual insurance companies, also seeking a declaratory judgment invalidating the 13% differential under ERISA. Petitioner HANYS and petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "Blue Cross") intervened in both actions as defendants. Respondents New York State HMO Conference and Health Services Medical Corporation and eleven individual HMOs then intervened in both actions as plaintiffs. The district court subsequently consolidated the two actions.

The district court granted summary judgment in favor of respondents, and enjoined the State of New York from enforcing the 13% differential against any commercial

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[8] There are other options as well. The New York law further includes an incentive targeted solely to payors that pay at the "commercial" rate and payors that pay charges: if the commercial insurer or charge payor pays the hospital bill in full within ten days, it may take a 2% discount off the payment. N.Y. Pub. Health Law § 2807-c(11)(e). The discount is not available to Blue Cross or to HMOs. Also, an ERISA plan may take itself out of the statute by paying a defined monetary benefit, which then is not affected at all by the differential.

insurer in connection with its coverage of an ERISA plan. The court first acknowledged that "the Surcharges do not directly increase a plan's costs or effect the level of benefits to be offered." Pet. App. A-71. It went on, however, to state that "the Surcharges at issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs." Pet. App. A-71 (footnote omitted). The court also pointed to the justification for the law—"that the Surcharges will increase the cost of obtaining medical insurance through any source other than [Blue Cross] to a sufficient extent that customers will switch their coverage to and ensure the economic viability of [Blue Cross]" (Pet. App. A-72)—as a basis for concluding that "even if the exact economic effect of the Surcharges cannot be determined at this stage in the litigation, . . . that effect is intended to be and is in fact substantial." Pet. App. A-73.[9] Having thus found that the law "relates to" ERISA plans within the meaning of the ERISA preemption provision, the court found that it was not a law "regulat[ing] insurance" within the meaning of the ERISA savings clause. Pet. App. A-88.

b. The court of appeals affirmed.[10] Applying the two-part test developed by this Court, *see, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990), the court of appeals conceded that "the challenged statutes do

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[9] The district court also said that the 13% differential diverts ERISA plan resources to a state-specified use unrelated to the health care of plan participants, Pet. App. A-74, and that, because hospital rates in other States may not include this cost, the statute creates potentially inconsistent obligations upon multi-state ERISA plans. *Id.* at A-74 to A-75.

[10] The Second Circuit had issued an earlier opinion which, for all intents and purposes here, was identical to its Amended Opinion. Because the earlier opinion did not address certain issues unrelated to this appeal, HANYS and other petitioners petitioned the Second Circuit for a rehearing.

not refer to ERISA plans." Pet. App. A-22. It held, however, that their "indirect economic impact upon ERISA plans" was enough to "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand*." Pet. App. A-22.

The court of appeals recognized that the New York law served a number of related purposes, stating: "[t]he 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers. In particular, the differential was meant to level [the] playing field for the Blues in their competition with commercial insurers." Pet. App. A-7 to A-8 (internal quotations omitted). Although the court did not find that any of these policies was itself incompatible with ERISA, it nonetheless determined that the differential impermissibly "increase[s] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits." Pet. App. A-23. Moreover, the court found that, in setting different rates for different patients according to their types of coverage, the surcharge "purposely interfere[s] with the choices that ERISA plans make for health care coverage" by making Blue Cross coverage more competitive with other health care coverage. *Id.* at A-22. Rejecting the contention that an indirect economic impact, by itself, is not sufficient to justify preemption under ERISA, the Second Circuit relied on a district court decision, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 U.S. Dist. Lexis 2011 (S.D.N.Y. Feb. 18, 1993), *reversed*, 27 F.3d 823 (2d Cir. 1994), for the proposition that "a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." Pet. App. A-24.

The court of appeals also ruled that the 13% differential is not saved from preemption by the ERISA savings clause. Having earlier said that the New York statutes

"purposely" sought to influence choices about coverage, Pet. App. A-22, the court took the view, for purposes of the savings clause, that the differential "aim[s] to regulate hospital rates." Pet. App. A-27. Furthermore, the court decided, the New York law satisfied only one of the three factors (the "McCarran-Ferguson factors") used to determine whether a law regulates insurance. Although the law did "help spread the risk of health care costs," Pet. App. A-28, it did not "regulate any practice that is integral to the insurer-insured relationship," *id.*, nor was it " 'limited to entities within the insurance industry.' " Pet. App. A-29 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49 (1987)).[11]

INTRODUCTION AND SUMMARY OF ARGUMENT

The court of appeals held that ERISA required preemption of a New York law that established one set of hospital rates for patients covered by Blue Cross, HMOs, and Medicaid, and a different (higher) set of rates for other patients, including those covered by commercial insurers and self-insured funds. Although the court accepted that the law was one of general application—and thus made no distinction between members of ERISA plans and other hospital patients—it nonetheless concluded that the "indirect economic impact upon ERISA plans" (Pet. App. A-22) was enough to warrant preemption. According to the court, the law was invalid under ERISA because (for plans choosing coverage subject to the higher rates) it "substantially increase[s] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," Pet. App. A-23, and because, solely as a result of the different rate levels, it "purposely interfere[s] with the choices that ERISA plans make for health care coverage." Pet. App. A-22. The court then went on to reject the argument that the law

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[11] The Second Circuit also rejected defenses based upon the Tax Injunction Act, raised by other petitioners, and laches on the 13% differential, raised by HANYS.

was saved from preemption under ERISA as a law "which regulates insurance." Pet. App. A-25 to A-29.

This analysis extends preemption under ERISA past any logical breaking point. Although ERISA contains a broad preemption clause, it cannot reasonably be applied to any and all generally-applicable state laws that, simply by affecting the cost of particular goods and services, have an "indirect economic impact" on ERISA plans. To the contrary, the history of the preemption provision gives no indication that "the field of private employee benefit programs"—the "field" from which state authority was displaced—was to include laws indirectly affecting the costs of ERISA plans. And, it is especially unlikely that Congress intended the general preemption provision of ERISA to displace traditional state authority over the regulation of health care (including hospital rates), given Congress' longstanding recognition of the States' responsibility for assuring adequate medical care for their citizens. This conclusion is reinforced by Congress' awareness of, and federal participation in, state programs that set different rates for different categories of payors, including commercial insurers.

The fact that ERISA plans have a choice of subscribing to Blue Cross (and thus potentially benefiting from the differential) does not make the New York law invalid. If States may shift costs among various payors—as respondents apparently concede that they may—it would make little sense to say that they may *not* do so whenever ERISA plans might be able to take advantage of the more favorable rates. It would make even less sense in the circumstances here, given that the differential favoring patients of Blue Cross merely reflects Blue Cross' historical assumption of burdens not assumed by commercial insurers and other payors. The New York law is thus quite the opposite of laws found to "relate to" ERISA plans on the ground that they *denied* employers or their plans the right to choose the benefits to be provided to

their employees. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

Even if state laws affecting costs can be said to "relate to" ERISA plans, however, the decision below is still incorrect. It is wholly inconsistent for the court of appeals to assert that the particular law here, by setting different rates for patients of different payors, impermissibly affects the choice of health care coverage and, yet, simultaneously deny that the law "regulates insurance" (and is thus within the ERISA savings clause). Moreover, if the law is regarded as "purposely interfer[ing]" with choices about insurance coverage, it plainly meets the criteria utilized by this Court for deciding whether a law falls within the ambit of the savings clause. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 743-44. Not only does it regulate the spreading of risk, but, contrary to the holding below, it regulates an integral part of the relationship between insurer and policyholder and is limited to those subject to insurance regulation. Thus, if the court of appeals is correct that the law is within the scope of the preemption clause, it is wrong that it is outside the scope of the savings clause.

ARGUMENT

I. ERISA DOES NOT PREEMPT GENERAL STATE LAWS MERELY BECAUSE THEY HAVE AN INDIRECT ECONOMIC IMPACT ON ERISA PLANS

This Court has frequently observed that, in determining the preemptive effect of federal law, the " 'ultimate touchstone' " is congressional intent. *See, e.g., Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). Although this inquiry naturally focuses on the language of the statute itself, *United States v. Alvarez-Sanchez*, 114 S. Ct. 1599, 1603 (1994), it is "guided by respect for the separate spheres of governmental authority preserved in our federalist system." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Construction of a federal statute thus begins "with an assumption that the historic police powers of the States [are] not to be superseded . . . unless that [is] the clear and manifest purpose of Congress." *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). And this presumption against preemption applies in two important aspects: first, it is employed to determine whether the federal law provides for preemption at all; and, second, it is used to identify what the scope of any preemption must be. *See Department of Revenue v. ACF Indus., Inc.*, 114 S. Ct. 843, 850 (1994) ("When determining the breadth of a federal statute that impinges upon or pre-empts the States' traditional powers, we are hesitant to extend the statute beyond its evident scope.").

It is well-recognized, of course, that ERISA has broad preemptive scope. *See, e.g., District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 584 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139; *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983). The statute has an express preemption provision—declar-

ing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA (29 U.S.C. § 1144(a))—and this Court has often described the language of that provision as "'deliberately expansive.'" *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). Applying that language, the Court has set forth a two-part test: a state law is preempted "'if it has a connection with or reference to [an ERISA] plan.'" *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988).

The court of appeals acknowledged that the New York law "do[es] not refer to ERISA plans" (Pet. App. A-22); it held, rather, that it ran afoul of "the less stringent 'connection with' standard . . . ." Pet. App. A-22. Under that standard, it is accepted that, to be preempted, a state law need not be "specifically designed" to affect ERISA plans. *See Ingersoll-Rand*, 498 U.S. at 139. While recognizing that many state laws of general application would have "only a 'tenuous, remote, or peripheral' connection with covered plans," *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1 (quoting *Shaw*, 463 U.S. at 100 n.21), this Court has held that state laws are preempted insofar as they establish certain rights and obligations with respect to ERISA plans. In particular, the Court has found preemption of state laws that, on their face or as specifically applied, define the duties owed by employers or their plans. See *Alessi* (duty to pay plan participants pension benefits without offset for workers' compensation); *Shaw* (duty to provide plan participants with coverage for pregnancy); *Pilot Life* (duty to process plan participants' benefit claims in accordance with state standards); *FMC Corp.* (duty to pay plan participants' benefit claims without subrogation); *Ingersoll-Rand* (duty

not to discharge employees to avoid payment of benefits).[12]

This Court has never held, however, what the court below held: that ERISA requires preemption of a generally-applicable state law on the sole ground that it has an "indirect economic impact upon ERISA plans." Pet. App. A-22. To the contrary, in the most analogous case, the Court concluded that ERISA did *not* bar application of a general state garnishment law, despite its express recognition that the law imposed "substantial administrative burdens and costs" on ERISA plans. See *Mackey*, 486 U.S. at 831. *See also Ingersoll-Rand*, 498 U.S. at 139 (noting that in *Mackey* "[t]he fact that collection might burden the administration of a plan did not, by itself, compel pre-emption"). The Court has subsequently made clear that preemption does not extend to "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.[13]

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[12] In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court found that a state law had a connection with ERISA plans because it effectively required employers to provide their employees with specified mental health coverage. The Court then concluded, however, that the law was saved from preemption to the extent that it applied to agreements between ERISA plans and their insurers. 471 U.S. at 739-47.

[13] In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court also held that ERISA did not preempt a state law requiring severance payments, which ordinarily fell within the purview of ERISA, because the law did not require the establishment or maintenance of an on-going plan. According to the Court, the mere fact that the cost of complying with the state law might, in turn, indirectly affect the decisions of an employer in creating or structuring its plans was no different from any other general financial obligation, and simply too far removed to have a connection to a plan. *Id.* at 14. *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 741 (stating that although a state law which mandates insurers to provide certain benefits relates to ERISA plans, state laws that "regulate such matters as the way in which insurance may be sold" to insureds, including ERISA plans, does not relate to ERISA plans.)

These principles should be controlling here. As we discuss below, it would be irrational to read the ERISA preemption clause to prohibit the States from regulating hospital rates in general, or from shifting costs among classes of hospital patients in particular, merely because that regulation would have an indirect economic impact on ERISA plans. Nor is that reading made any more rational by the fact that regulation of rates may influence ERISA plans' choices about coverage. As Congress is well aware, States commonly act to assure that the costs of health care are reasonably allocated among those needing services, and that action is not rendered invalid simply because, under a particular regulation, ERISA plans (like everyone else) may have the option of benefiting from a particular allocation rather than bearing the burden of it. Thus, while preemption under ERISA is concededly broad, it does not grant ERISA plans immunity from the economic effects of state laws apportioning the costs of health care among all recipients.

A. Nothing in ERISA Justifies Widespread Preemption of General State Laws Affecting the Costs to ERISA Plans.

It might be possible, as a literal matter, to read the phrase "relates to" to encompass any state law having an indirect economic impact on ERISA plans. But there is little reason to adopt that reading, and a number of important reasons to reject it. *See Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) ("ERISA's preemption provision is very broad, but the word 'related' must not be taken literally").

As an initial matter, to preempt all generally-applicable state laws merely affecting (or, even, substantially affecting) the costs of an ERISA plan would result in a significant reallocation of federal and state authority.[14] Apply-

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[14] Given that ERISA plans must operate as commercial entities, it seems obvious that a vast array of state laws will have, in one form or another, a significant economic impact on ERISA plans.

ing the usual presumption against that restructuring, *see Cipollone*, 112 S. Ct. at 2617, it is reasonable to expect that, if Congress intended so wide-ranging a displacement of state law, it would have made that intention clear on the face of the statute or, at least, in the legislative history. *See Massachusetts v. Morash*, 490 U.S. 107, 119 (1989) ("[a]bsent any indication [in ERISA] that Congress intended such far-reaching consequences, we are reluctant to so significantly interfere with 'the separate spheres of governmental authority preserved in our federal system' ") (quoting *Fort Halifax*, 482 U.S. at 19).[15] Yet, even giving due weight to the "deliberately expansive" language of its preemption clause, ERISA contains little evidence that preemption of state law was to extend so far. To the contrary, the broad language of Section 514(a) was added late in the legislative process, and the legislative history—while indicating that it was intended to reserve to the federal government "the sole power to regulate the field of employee benefit plans," 120 Cong. Rec. 29,197 (1974) (Rep. Dent)—gives no hint that the

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Some laws (*e.g.*, laws affecting commercial real estate) may substantially raise the costs of an ERISA plan; other laws that operate against the employer (*e.g.*, environmental laws) may reduce the funds available for contribution to an ERISA plan. And, of course, certain laws provide for the closing down of businesses, such as nursing homes, unable to meet specified standards. *See, e.g.*, N.Y. Pub. Health Law § 2806. All these laws would seem to be preempted under the reasoning of the decision below.

[15] As this Court has observed, the principal protection afforded to States against displacement of their authority by the national government lies in "procedural safeguards inherent in the structure of the federal system." *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 552 (1985). Those safeguards cannot operate effectively, however, if federal laws preempting traditional state authority fail to contain a clear indication, not just of some intention to preempt, but of the degree of the preemption. *See Alessi, supra*, 451 U.S. at 522 (preemption must be "unmistakably so ordained"). And, we submit, the more unusual the degree of displacement, the more certain the indications of congressional intention must be.

"field" was to encompass any and all laws indirectly imposing costs on ERISA plans.

The original House and Senate bills provided only for preemption of state laws relating to the particular matters addressed by ERISA.[16] Under those bills, therefore, ERISA would not have preempted a state law that regulated the form, amount, or structure of plan benefits, provided that it did so in a manner as to which ERISA is silent. However, concerned that this formulation would open "the door to multiple and potentially conflicting state laws hastily contrived to deal with some particular aspect of [ERISA plans] not clearly connected to the federal regulatory scheme," the Conference Committee ultimately opted for the broader language currently found in ERISA. 3 Legislative History 4770-71. Thus, instead of preempting only those state laws dealing with matters on which ERISA has spoken, the Conferees agreed that ERISA would displace all "State action in the field of private employee benefit programs." 3 Legislative History 4771.

There is no indication, however, that the Conferees regarded "the field of private employee benefit programs" as vast enough to encompass general state laws having nothing more than an indirect economic effect on ERISA plans.[17] Citing examples of state laws that would be pre-

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[16] The House bill stated that ERISA would supersede laws that "relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies." H.R. 2, 93d Cong., 2d Sess., § 514(a) (1974), *reprinted in* 3 Senate Committee on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, at 4657-58 (Committee Print 1976) ("Legislative History"). The Senate bill stated that ERISA would preempt state laws that "relate to the subject matters regulated by this Act." H.R. 2, 93d Cong., 2d Sess., § 699(a) (1974), 3 Legislative History 3820.

[17] Had the preemption provision not been broadened, the laws at issue in *Alessi*, *Shaw*, and *FMC Corp.*—to take several examples—would likely not have been preempted. Nothing in ERISA addresses

empted, the Conference Report referred to state laws directly pertaining to employee benefit plans. These examples included "State laws compelling disclosure from [ERISA] plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans—unless a criminal statute of general application —[and] establishing State termination insurance programs." 3 Legislative History 4771. Furthermore, the Conferees indicated that, in light of the preemption of State law, "a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* But that field—"issues involving rights and obligations" under ERISA plans—is quite different from, and less open-ended than, a field encompassing laws that, by regulating the price of various goods and services, simply have an indirect effect on the financial operations of employee benefit plans.

Other parts of the legislative history confirm that point. Following his oft-cited statement that ERISA's "crowning achievement [was] the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans," *see, e.g., Shaw*, 463 U.S. at 99; *Pilot Life Ins. Co.*, 481 U.S. at 46, Representative Dent, a sponsor of ERISA, explained that its preemption provision was patterned after the approach employed in the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e *et seq.*); 3 Legislative History 4670. Significantly, however, the Health Maintenance Organization Act preempts only certain enumerated state actions that impair the formation and operation of HMOs, and not any and all state actions that might affect HMOs.[18] 42 U.S.C. § 300e-10. And,

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the issues of offsetting workers' compensation payments, or providing coverage for pregnancy, or requiring subrogation of rights in return for payment of benefits.

[18] Section (a) of the preemption provision states:

during the floor debates, Senator Javits, another sponsor of ERISA, explained that, while ERISA would preempt bar association rules regulating the "form and content" of an ERISA legal services welfare plan, it would *not* preempt ethical rules and guidelines and disciplinary actions that apply to attorneys providing services to such plans. 3 Legislative History 4789. These sponsors, therefore, strongly suggested that preemption under ERISA would reach any state laws that affect ERISA plans by regulating the form and content of their benefits, but would not extend to other state laws that might indirectly affect the operation of ERISA plans.

(a) Restrictive State laws and practices.

In the case of any entity

(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or

(E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, and

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans)

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

The legislative history does make clear that preemption was intended to advance "the interests of uniformity with respect to interstate plans . . . ." 3 Legislative History 4771. Indeed, this Court has specifically identified "the threat of conflicting or inconsistent State and local regulation" as "the problem that the pre-emption provision was intended to address." *Fort Halifax*, 482 U.S. at 9 (quoting 120 Cong. Rec. 29,197, 29,933 (1974) (Rep. Dent)). But an interest in "uniformity" does not lead to preemption of state laws affecting the costs of ERISA plans. If preemption of a particular state law is to serve that interest, it is necessary that the law regulate an area in which uniformity might otherwise be expected. That is hardly the case with respect to the costs of an ERISA plan: with or without preemption of state law, those costs will vary widely from state to state, as the costs of health care and its coverage vary dramatically from state to state. Thus, the broad rationale adopted by the court of appeals would lead to extensive preemption of state law without advancing any legitimate interest protected by ERISA. *See generally Fort Halifax*, 482 U.S. at 8-15.

B. ERISA Does Not Preempt Traditional State Authority To Regulate Hospital Rates.

It is true that the *holding* of the decision below, as opposed to its *rationale*, applies to a law regulating the cost of one particular good or service: *i.e.*, in-hospital care. But we see no grounds for saying that States may have laws affecting the price of some goods and services purchased by ERISA plans, but not in-hospital care. Although the court of appeals remarked that the New York law "substantially increase[d] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" (Pet. App. A-23), that statement, even if correct, does not provide a basis for distinguishing hospital costs from other costs: *any* expenditure by a plan ultimately reduces the funds available to provide benefits. Put another way, if the test for preemption were

whether an ERISA plan could offer more benefits in the absence of a particular state law, very few state laws would be able to escape preemption.

In any event, a reading of ERISA that preempted any state law affecting the costs of health care, or even hospital care, would be far too broad. Given the important role of ERISA plans in providing health care coverage, *see* Pet. App. A-6, it follows naturally that the most garden-variety regulation of hospitals will have an indirect economic effect—often a substantial effect (*see* Pet. App. A-24)—on ERISA plans. For example, New York (like many States) establishes requirements for the staffing of hospitals, sets quality assurance standards, and imposes obligations for disposal of medical waste, each of which forces hospitals to incur costs that are built into their rates. Indeed, the impact of many of these laws on hospital rates (and, potentially, on insurance premiums) is far greater than the impact of the differential here. Thus, if the court of appeals were correct that indirect economic effects were enough to require preemption, state regulation of hospital care would be severely curtailed.[19]

Seeking to avoid that uncomfortable result, respondents try to narrow the decision below in a manner that, in the

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[19] It is undisputed that members of ERISA plans are significant consumers of hospital services. They are not, however, the predominant users of in-patient hospital services. Although the court of appeals stated that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans," Pet. App. A-6, that figure is somewhat misleading for several reasons. First, though not clear from the awkward wording, it excludes patients without "private health care insurance" (*e.g.*, Medicaid). Second, it refers to the market share of ERISA plans for *all* health care coverage—which includes outpatient, physician, and other non-hospital services, not just the in-patient services at issue here. And, finally, it specifically excludes Medicare or other elderly patients, who are the most extensive users of *hospital* services. To the extent that it might be relevant, ERISA plans cover approximately 25 percent of all in-patient services in New York.

end, aptly demonstrates its inherent irrationality. While respondents argue that *this* law is preempted, they take the position that a law simply setting the rates for hospital service would *not* be preempted. *See, e.g.*, Br. in Opp. 4, 6, 13, 18; C.A. Br. 1, 17. But this concession is openly at odds with the theory that state laws are preempted because, by affecting costs, they have a "connection with" ERISA plans. By that standard, the DRG rates themselves "affect" the costs of ERISA plans in the most unequivocal way: by establishing the actual price to be paid for particular in-hospital procedures.

The court of appeals, for its part, seemed concerned that the New York law set rates unequally: that is, that it increased the rates of certain patients, but not others. But the imposition of different rates does not turn a valid law into an invalid one. To start with, it is flatly inconsistent with the preemption provision itself to make preemption turn on whether a law has an *adverse* effect on ERISA plans. That provision does not draw a line between state laws that increase the price of services purchased by ERISA plans and laws that decrease the price of services purchased by plans; as a matter of simple statutory interpretation, either type of law "relates to" ERISA plans in the same manner. And, this Court has expressly held that ERISA, where it properly applies, preempts even laws beneficial to ERISA plans. *See Mackey*, 486 U.S. at 829-30.[20]

In any event, the setting of higher rates to offset lower charges to particular patients does not, in and of itself, require preemption of state law. Once again, respondents

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[20] We note that respondents do not challenge several components of the New York rate-setting statute that operate to their benefit. For example, they do not challenge the right of HMOs (but not other payors) to negotiate payments to hospitals, *see* note 6 *supra*, presumably because commercial insurers are setting up their own HMOs. Nor do they challenge the 2% discount offered to commercial insurers (but not Blue Cross or HMOs) for payment to hospitals within 10 days. *See* note 8 *supra*.

ultimately concede this point: in this Court they have emphasized that they are *not* claiming preemption of laws increasing charges to certain patients to take account of patients unable to pay the regular charges. *See* Br. in Opp. at 4, 18. But this concession, too, seriously undercuts their position, for, at least insofar as complaints about added costs to ERISA plans are concerned, it makes no difference whatever that the reallocation of costs benefits charitable patients (in the DRG rates themselves), or Medicaid patients (in the differential), or patients of Blue Cross (in the differential). In each case, the State is simply recognizing that certain payors for different classes of patients—often those with lesser resources or a greater need for services—should not be required to bear an equal share of the overall costs.

It is likewise instructive that respondents do not challenge the differential to the extent that it imposes lesser costs on Medicaid. To challenge that differential, of course, respondents would have to take the dubious position that Congress meant to limit States to setting *identical* hospital rates for all patients, regardless of individual or collective circumstances. Otherwise, it would follow that States could exercise their traditional authority to shift the costs of care among payors representing those better able to bear those costs and those less able to do so. New York has done just that with respect to patients covered by Medicaid: the law simply acknowledges that, given the burdens undertaken by the Medicaid program, the rates charged to that program should be lower than those charged to patients covered by certain other third-party payors.

The same justification exists, however, for charging lower rates to patients covered by Blue Cross. Although the law does not subject Blue Cross patients to the same charges paid by patients covered by commercial insurance—as one official stated, it seeks to "level the playing field"—it establishes that differential for good reason.

Unlike commercial insurers, Blue Cross has long followed a policy of open enrollment, effectively serving as the insurer of last resort for citizens of New York. Unlike commercial insurers, it employs a community-rating system. And, unlike commercial insurers, it makes advance payments to hospitals to assist them in maintaining a secure financial position.[21]

Each of these undertakings—which constitute an important part of the overall health care system in New York—has a negative impact on the financial condition of Blue Cross plans: that is, each of them tilts the "playing field" *against* Blue Cross. In light of that background, however, there is no more cause to prevent New York from granting lower rates to patients of Blue Cross, than to prevent it from granting them to patients covered by Medicaid. As it does for Medicaid patients, or for charitable patients, the State is simply taking account of the need of various classes of patients for hospital services and their respective abilities to pay.[22]

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[21] Blue Cross plans, as non-profit entities, are also subject to a complex regulatory scheme that does not apply to commercial insurers. Thus, for example, Blue Cross premiums, unlike those of commercial insurers, must be approved by the Superintendent of Insurance after public hearings; the Superintendent may refuse such approval if he finds that the premiums, or the premiums derived from a rating formula, are excessive, inadequate, or unfairly discriminatory. N.Y. Ins. Law § 4308. Blue Cross plans also face special regulatory controls on their administrative expenses, reserves, and surpluses. N.Y. Ins. Law §§ 4309(a)-4310. And Article 43 corporations, like Blue Cross, are limited to providing health insurance, while other insurers, not so limited, can enter into other lines of business, from life insurance to car leasing, in order to subsidize their health care coverage. Respondents do not challenge these disparities in treatment which may create incentives *not* to insure with Blue Cross because of higher premium costs.

[22] At times, in fact, the State has linked the amount of the differential to the enrollment policies of the various entities. Beginning in 1990, the State increased by two percent the rates of any Blue Cross plan that did not offer, at a minimum, its basic hospital and medical insurance on a continuous open enrollment basis for the

There is no justification, therefore, for construing ERISA to bar States from setting different rates for different patients. Again, while that might be a possible (if exaggerated) reading of the words "relating to," it would severely limit the authority of States to regulate their health care systems in a rational way. And that reading would not seriously advance any interest in national uniformity, because—whether States regulate rates, or not—the rates charged for health care inevitably reflect a shifting of costs among different patients.[23] Thus, it would deprive States of an important mechanism for im-

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prior 12 months, or that did not continue such open enrollment policy for the 12 months of 1990. 1988 N.Y. Laws, ch. 2, § 11 (codified at N.Y. Pub. Health Law § 2807-c(11)(i)). At the same time, it lowered by two percent the rates of any commercial insurer that offered open enrollment and community rating under certain conditions. 1988 N.Y. Laws, ch. 2, § 11 (codified at N.Y. Pub. Health Law § 2807-c(11)(ii)). In addition, there were other circumstances whereby the failure of a Blue Cross plan to provide open enrollment resulted in a 2% increase in its rate of payment to hospitals. 1988 N.Y. Laws, ch. 2, § 11. These statutory provisions were first extended from 1990 through December 31, 1993 (1990 N.Y. Laws, ch. 922, § 12), but were repealed and replaced by the statute imposing the 11% differential. 1992 N.Y. Laws, ch. 55, § 348.

[23] *See* CBO Papers, *Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift"?*, Cong. Budget Office, May, 1993, at vi ("The contributions of the different sources used to cover unreimbursed costs changed over time. The share of unreimbursed costs offset by private payers increased from 37% in 1980 to 55% in 1989, and the proportion offset by state and local subsidies decreased from 27% in 1980 to 10% in 1989"); *id.* at vi ("Hospitals offset most of the rise in unreimbursed costs during the 1980's by generating higher revenues from private payers, a practice commonly known as 'cost shifting'"); *id.* at 4 ("The practice of cost shifting from the public sector to the private sector does not imply that public-program payment rates are inappropriate or 'too low' or that the costs hospitals incur are 'too high'"); *id.* at 4 ("Evidence of cost shifting indicates that one important way hospitals have responded to public-program controls on spending has been to generate higher revenues from the private sector").

proving the delivery of health care to all citizens, with no obvious benefit to the goals served by ERISA.

C. Congress Has Recognized State Authority To Regulate Hospital Rates.

It is also highly unlikely that Congress, by enacting the general preemption provision in ERISA, meant to preempt the authority of States to regulate health care, including the rates charged for hospital services. Over the past 25 years Congress has frequently recognized, and approved, efforts by States (including New York) to address the problems of restraining health care costs and providing good medical care. During that period, Congress has not only authorized, but has actively encouraged, States to engage in hospital rate-setting activities covering all payors, including ERISA plans and their insurers.

1. Beginning in 1967, Congress has repeatedly addressed the authority of the Secretary of Health and Human Services (and, before that, the Secretary of Health, Education, and Welfare) to waive federal Medicare requirements in order to allow Medicare payments to be set by state reimbursement systems. As shown below, Congress was clearly aware of all-payor reimbursement systems—including differentials among various payors—in granting authority to the Secretary for Medicare to participate in state systems.[24]

This grant of authority to the Secretary originated in a 1967 Medicare Act Amendment, which allowed the Secretary to reimburse hospitals pursuant to an approved demonstration reimbursement system, and to waive federal Medicare and Medicaid reimbursement requirements in order to do so. 42 U.S.C. § 1395b-1. Congress was concerned, however, that the system cover *all*, not just

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[24] As noted above, *see* note 19 *supra*, any "all-payor" system necessarily includes ERISA plans and their insurers because members of plans are significant recipients of in-hospital care.

some, third-party payors. In 1980, therefore, Congress authorized the continuation of such demonstration projects only up to the time that a "*third-party payor reimburses such a hospital on a basis other than under such system.*" Pub. L. No. 96-499, § 903 (codified at 42 U.S.C. § 1395f(b)(3)(A)) (emphasis added). The Conference Committee, which added this limitation, expressly stated that the authority given to the Secretary terminated if "the State's reimbursement system is no longer *applicable to all third-party payors.*" H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 147 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5938 (emphasis added).[25]

In 1982, Congress expanded the Secretary's authority to make Medicare payments "in accordance with a hospital reimbursement control system in a State" if, *inter alia*, the state system encompasses "at least 75 percent" of all in-patient revenues and does not prevent HMOs from negotiating their rates. Pub. L. No. 97-248, Title I, § 101(a)(1) (codified at 42 U.S.C. § 1395ww(c)(1), (c)(1)(A) and (D)). These conditions, once again, necessarily envision state control over the rates of all private insurers and recognize the States' power to preclude negotiated rates for non-HMOs (or even for HMOs, although at the expense of ineligibility for a waiver). Although the Secretary was not compelled to grant a waiver of federal requirements, and thereby acquiesce in state control over hospital rates, the Conference Committee nevertheless stated that it "expect[ed]" the Secretary to do so. H.R. Conf. Rep. No. 760, 97th Cong., 2d Sess. 422 (1982), *reprinted in* 1982 U.S.C.C.A.N. 1202.

The subsequent 1983 amendments to the Medicare Act are also significant, in several related respects. Most im-

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[25] As late as 1990, Congress has subsequently reaffirmed that the "all third party payor" condition in 42 U.S.C. § 1395f(b)(3) continues in force and effect. Pub. L. No. 101-508, § 4008(i)(3), 104 Stat. 1388-51 (amending 42 U.S.C. § 1395f(b)(3)).

portant is the fact that the amendments made mandatory the approval of a state request that Medicare participate in its all-payor system: if the stipulated conditions are met, the Secretary "shall approve" the request. Pub. L. No. 98-21, § 601(c)(3) (codified at 42 U.S.C. § 1395ww (c)(5)(A)). The House Report accompanying the legislation provided: "Your Committee believes that State systems provide a laboratory for innovative methods of controlling health care costs and should, therefore, not be limited to one methodology." H.R. Rep. No. 25, 98th Cong., 1st Sess. (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 365-66. Furthermore, the Committee report stated: "Your Committee believes that State cost containment systems have proven effective in reducing the cost of hospital care and that such systems should be encouraged." H.R. Rep. No. 25, at 147-48, *reprinted in* 1983 U.S.C.C.A.N. 366-67. It then went on to declare that "State systems covering all payors have proven effective in reducing health costs and should be encouraged. Such State programs may be useful models for our national system." *Id.*

At the time of these amendments, Congress specifically reviewed the all-payor systems in New York and other States.[26] *See* H.R. Rep. No. 25, at 147-48, *reprinted in* 1983 U.S.C.C.A.N. 366-67. Then, as now, the New York all-payor system did *not* provide for uniform rates: to the contrary, Blue Cross received a discount of 12%-15% as compared to commercial insurers. N.Y. Pub.

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[26] These 1983 amendments were preceded by Congressional hearings in which officials from New York and other States described their States' all-payor systems and urged the preservation and expansion of the Secretary's Medicare waiver authority. *See Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 1st Sess. 103 (1983) (Statement of R.M. Crane, N.Y.S. Dep't of Health); *Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. pt. 1, 146-56 (1983) (same).

Health Law § 2808-c(1) and (6).[27] It is thus apparent, first, that Congress has repeatedly endorsed and encouraged state all-payor systems and, second, that Congress has been fully aware that, under all-payor systems, all payors' rates are not the same. Given that background, it is utterly implausible to think that Congress nonetheless intended ERISA to preclude States from establishing different hospital rates for different payors.

2. Evidence of Congressional approval of all-payor systems, including that used in New York, is also found in its approach to the financing of uncompensated care costs. Uncompensated costs may arise in various ways. For example, hospitals incur bad debts when they are unable to collect the uninsured portion of their charges for which patients, including patients insured under ERISA plans, are personally liable. In addition, New York hospitals provide substantial amounts of charity care to the uninsured and under-insured, and, in large measure, are required to do so by federal and state mandates.

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[27] Congressional awareness that all-payor systems did not mean that all payors paid the same rates is established by a 1987 report to Congress by Otis R. Bowen, M.D., then Secretary of Health and Human Services. Otis R. Bowen, M.D., Department of Health and Human Services, *Report to Congress: The Relationship of Medicare PPS to All Payer Systems and Cost-Shifting*, No. 87-1 (Jan. 1987). Among the findings reported by Secretary Bowen to Congress were the following:

> While a hospital may have one set of charges, historically not all payers have paid the same amounts for similar services . . . .
>
> Discounts might be granted for the following reasons:
> — to reflect charge discounts historically received by certain payers (e.g. BC, Medicaid) . . . .
>
> — The fact that payment differentials exist among the payers is well-documented . . . .

Id. at II-47, II-53-54, III-1.

The Medicaid Act requires that rates for hospital services "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." 42 U.S.C. § 1396a (a)(13)(A) (1988). To comply with this requirement, New York includes in the DRG calculation an adjustment reflecting the added costs of uncompensated care. Through a pooling and redistribution system, New York apportions the costs of bad debt and charity care among all payors, except Medicare. N.Y. Pub. Health Law § 2807-c(14). By virtue of a "Special Rule," Congress specifically exempted New York from specific federal requirements applicable to all other States, finding that the New York bad debt/charity care pooling system was deemed to comply with the disproportionate share mandate. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4112(e), 101 Stat. 1330-150 (1987) (codified at 42 U.S.C. § 1396r-4(e)(1)(A)(i) [1988]); H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 753 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1245, 2313-1499.

This approval, once again, indicates that Congress was aware of, and in full support of, efforts by New York to apportion the costs of hospital care among *all* payors. That being so, it is impossible to imagine that Congress meant, by a general preemption provision in another statute, to declare ERISA plans—and their insurers—*exempt from* laws distributing hospital costs among all payors. It is far more reasonable to think that Congress had no intention at all to shield ERISA plans and their insurers from the obligations borne by other recipients of hospital care, for the simple reason that it would not have thought hospital rates to be within the "field" at which the preemption provision of ERISA was aimed. ERISA plans may prefer to have an exemption, of course, but that is not the same thing as saying that Congress intended for them to have one.

D. The Plans' Option To Benefit From The Lower Blue Cross Rate Is Not A Basis For Preemption.

The court of appeals did not rest its holding of preemption solely on the ground that the New York law affected the costs of ERISA plans: it said, in addition, that the law, by setting lower rates for patients covered by Blue Cross, "purposely interfere[s] with the choices that ERISA plans make for health care coverage." Pet. App. A-22.[28] To some degree, that observation is correct: unlike the lower rates for Medicaid patients, the lower rates for Blue Cross patients might influence consumers (including ERISA plans) to elect Blue Cross coverage.[29] But, for several reasons, this possibility does not justify preemption of the law.

First of all, unless ERISA preempts *all* differences in rates, the theory that it preempts the lower rates for *Blue Cross* patients must turn upon a decidedly odd proposition: that state law providing for lower rates is preempted if—but, apparently, only if—ERISA plans may *benefit* from the lower rates. According to that view, the flaw in the different rates between Blue Cross patients

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[28] State laws, of course, may affect numerous decisions made by ERISA plans. For example, if the court of appeals' reasoning were followed to its logical extent, it would appear that States would be precluded from setting tuition at state universities. Inasmuch as tuition at state universities is lower than tuition at private universities, that disparity might affect the decisions of ERISA scholarship funds (*see* section 3(1) of ERISA, 29 U.S.C. § 1003(1)) about the levels of coverage to be provided.

[29] As noted previously (*see* pages 8-9, *supra*), unlike the state laws at issue in *Alessi*, *Shaw* and *FMC Corp.*, New York law allows ERISA plans to provide whatever benefits they want in whatever manner they want. ERISA plans may decide to self-insure, purchase Blue Cross insurance, purchase commercial insurance, or provide coverage through HMOs. Similarly, some ERISA plans may choose to cover expenses related to certain kinds of medical procedures, whereas others may not. And, some ERISA plans may cover 100 percent of ordinary medical expenses, whereas others may cover any fraction of that amount.

and commercially insured patients is that those paying the higher rates actually have a choice not to do so (by electing coverage from Blue Cross). But it is, frankly, difficult to see why Congress would regard the existence of that choice as an evil to be foreclosed. After all, nothing in the New York law requires ERISA plans to purchase Blue Cross coverage if they prefer other options. The differential simply serves the function of broadening choices for consumers (including ERISA plans) that might otherwise be deterred from selecting Blue Cross coverage because of added costs resulting from its unique obligations.

It might be different, of course, if the choice were not really a choice but a disguised mandate, but no credible argument of that sort can be made here. In the first place, the differential affects only one of many services covered by health care plans. Moreover, it is self-evident that decisions by ERISA plans regarding the most appropriate form of coverage will take account of far more than just the differential. In making that decision, plans would consider a number of other things: the quality of the service offered, the claims processing and sophistication of information systems, as well as the package of benefits offered. J.A. 268, 270-71. To what extent the differential may have an impact upon this choice will also depend upon what in-patient procedures are covered by the insurance, what out-patient procedures are covered, how large and how healthy the risk pool is, what alternative treatment settings are available, and the myriad other factors considered by insurers before determining whether to underwrite and spread a risk. The cost of in-hospital services will be one, but only one, element to be considered.[30]

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[30] We note that HANYS opposed summary judgment on the ground that, insofar as respondents claimed preemption on the basis of a substantial economic impact on plans, there remained a material issue of disputed fact precluding summary judgment. As a practical matter, discovery and (potentially) an evidentiary hearing were necessary to determine what that impact was. For

The law is very different, therefore, from laws struck down by this Court on the ground that they effectively required plans to provide particular kinds of coverage to their members. In *Shaw*, for example, this Court held that two New York laws were preempted by ERISA because, as interpreted and applied, they compelled ERISA plans to provide particular benefits. The Court stated that "the Human Rights Law, which *prohibits* employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which *requires* employers to pay employees specific benefits, clearly 'relate to' benefit plans." 463 U.S. at 97 (emphasis added). Similarly, in *Metropolitan Life*, the Court found that a Massachusetts law "related to" ERISA plans because it compelled them, directly or indirectly, to provide a designated level of mental health benefits. Again, the Court noted that, while the law was "not denominated a benefits-plan law, it bears indirectly but substantially on all insured benefit plans, for it *requires* them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 739 (emphasis added).

The problem with those laws, however, was just the opposite of the problem asserted by respondents here: that is, the laws left the plans *without* a choice. The laws thus converted decisions properly made by ERISA plans into decisions of the State. Not only does that kind of usurpation put States in a role plainly not contemplated

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example, insured plans pay insurance premiums, not hospital rates. There is no proof in the record of the extent to which any differential over 14 years, or the 13% differential over five years, has been reflected, if at all, in the premiums that respondents charge. Nor have respondents suggested in the record that their premiums would be reduced if the 13% differential were eliminated. The very fact that the Legislature saw a need to add an 11% surcharge shows that the 13% differential did not have the influence on consumer decisions that respondents have repeatedly suggested.

by ERISA (unless it otherwise falls within the savings clause of the Act), but it raises obvious concerns about the ability of ERISA plans to satisfy varying requirements from state to state. By contrast, a law merely providing for greater choice—so long as the choice is real and not a sham—does not offend any of the core interests protected by ERISA.[31]

II. TO THE EXTENT THAT THE NEW YORK LAW PURPOSELY AFFECTS CHOICES ABOUT COVERAGE, IT FALLS WITHIN THE ERISA SAVINGS CLAUSE

Having found that the New York law "purposely interfere[s] with the choices that ERISA plans make for health care coverage," Pet. App. A-22, the court of appeals nonetheless agreed with respondents that it was *not* a law "which regulates insurance" within the meaning of the ERISA savings clause. But respondents cannot have it both ways. If the law "relates to" ERISA plans because it purposely interferes with their decisions about coverage, then it "regulates insurance" and is not preempted. *See* 29 U.S.C. § 1144(b)(2)(A) ("[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").[32]

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[31] To bar States from using economic incentives to encourage consumers (including ERISA plans) to make certain choices would deprive them of an important form of regulation. For example, States may increase in-patient rates to encourage use of ambulatory or out-patient services. Although that disincentive might affect the choices made by members of ERISA plans, so long as ERISA plans are not singled out for special treatment, or their right to elect one form of coverage over another is not precluded, this kind of regulation properly remains within the scope of legitimate state authority.

[32] The relevant part of the district court judgment enjoined the defendants only "from enforcing [the] surcharges against any commercial insurers or HMOs in connection with their coverage of

As we have just discussed, we disagree with the view that a law affecting the costs of an ERISA plan "relates to" that plan within the meaning of Section 514(a), merely because the indirect economic impact of the law may affect choices about insurance coverage. But if that is the case—and laws affecting choices about coverage are thus treated as the functional equivalent of laws mandating particular coverage—then the decision of this Court in *Metropolitan Life* indicates that the savings clause must apply as well. There, the Court held that a law requiring "[a]ny blanket or general policy of insurance . . . or any policy of accident or sickness insurance . . . or any employees' health and welfare fund" to provide certain minimum mental-health-care benefits—while it "related to" ERISA plans—was saved from preemption as a law "which regulates insurance." Declining to read the savings clause narrowly, the Court concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." 471 U.S. at 746.

The same reasoning applies here. If there is no difference—for purposes of applying the "relates to" language of Section 514(a)—between laws mandating benefits and laws influencing the choice of benefits, then there is no good reason to distinguish between those laws in applying the savings clause. The Court in *Metropolitan Life* noted that, "while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power *over much of the same regulation.*" 471 U.S. at 739-40 (emphasis added). The court of appeals was thus quite wrong in seeking to construe the savings clause narrowly in order to pre-

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any ERISA plans." Pet. App. A-89 to A-90. Because the district court judgment did not enjoin enforcement of the surcharges against patients of self-insured funds, including self-insured ERISA plans, we do not address whether, with respect to the latter, the "deemer" clause would require preemption of the surcharges. *See generally, FMC Corp.*, 498 U.S. at 60-63 (construing 29 U.S.C. § 1144(b)(2)(B)).

serve the broad scope of preemption. *See* Pet. App. A-28 ("[t]he more expansively the savings clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable"). As the Court pointed out in *Metropolitan Life*, a grudging reading of the savings clause directly conflicts with the governing presumption against preemption of traditional state regulation. 471 U.S. at 741 ("[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope").[33]

The conclusion that the New York law is "saved" also follows from a straightforward application of the tests used by this Court to determine the scope of the savings clause. In determining whether the savings clause applies to a particular law, the Court first looks to "a common-sense understanding of the phrase 'regulates insurance.'" *Pilot Life*, 481 U.S. at 50. In this regard, the Court has observed that "[a] common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. The Court has thus found that general tort laws or laws generally regulating enforcement of contracts, 481 U.S. at 50, do not regulate insurance. But a law allocating costs within the insurance industry—and "purposely" affecting the rates charged to purchasers of insurance—would seem to fit comfortably within that definition.

The court of appeals, however, took a different view. According to that court, the "common-sense inquiry re-

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[33] That presumption is especially apt with respect to matters involving insurance. This Court has noted—with respect to the McCarran-Ferguson Act (15 U.S.C. § 1011 *et seq.*)—that Congress had the "primary objective of granting the States broad regulatory authority over the business of insurance." *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202, 2210 (1993).

veals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates." Pet. App. A-26 to A-27. But this statement cannot be reconciled with its earlier characterization of the law as purposely directed towards influencing the choices made by ERISA plans (and other consumers) regarding insurance coverage. If that characterization of the law is accepted—as it was for purposes of applying the "relates to" language of the preemption provision—then the law must be regarded as aiming, not just at hospital rates, but at the rates of insurers. That being the case, it does not matter that the law carries out its purpose indirectly by the mechanism of adjusting hospital rates, rather than by more traditional forms of direct regulation. *See Metropolitan Life*, 471 U.S. at 741 (rejecting argument that only "traditional laws" regulating insurance are subject to the savings clause).

The so-called "McCarran-Ferguson Act factors" also support application of the savings clause here. Like a mandated-benefit law, a law seeking to affect insurance choices plainly "regulates the spreading of risk." *Metropolitan Life*, 471 U.S. at 743. Indeed, the court of appeals recognized that the New York law satisfied this factor: it observed that "[b]ecause the 13% and 11% surcharges are designed to encourage ERISA plans—with generally healthier persons—to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs." Pet. App. A-28.

The court of appeals was incorrect, however, in concluding that the other two factors were not satisfied.[34] In *Metropolitan Life*, this Court found that a law "limit-

[34] This Court has not held that each of the three criteria must be satisfied. To the contrary, it has said that "[n]one of these criteria is necessarily determinative in itself" (*United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)), language suggesting that the failure to meet one of the criteria is consequently not "determinative." In any event, for the reasons stated in the text, we believe that all criteria are satisfied here.

ing the type of insurance that an insurer may sell to the policyholder" satisfied the second factor: that is, it was a law "regulat[ing] an integral part of the relationship between the insurer and the policyholder." 471 U.S. at 743. Again, if there is no material difference under ERISA between laws "limiting" the type of insurance to be sold and laws "affecting" the type of insurance to be purchased, the latter law likewise regulates an integral part of the relationship between insurer and policyholder. In either case, it is the coverage provided to the policyholder that is ultimately at issue.

The court was also mistaken in saying that the New York law does not impose requirements only on insurers. *See* 471 U.S. at 743. If the law is regarded as simply setting hospital rates, that conclusion would be correct. But insofar as the law is regarded as deliberately affecting rates for coverage of hospital costs—the "playing field" for Blue Cross, commercial insurers, self-insured funds, and HMOs—it is, to that extent, imposing requirements upon insurers. And it is that action by the State to which respondents object: that the law interferes with plans' choices *about insurance coverage*.

The application of the law to HMOs does not affect this conclusion. Although HMOs provide health care directly, they bear many of the same risks borne by traditional insurers. Thus, by agreeing to provide care for a predetermined charge, HMOs assume the risk that the need for care will be greater than expected at the time of the agreement with the subscriber. In that respect—the respect in which the New York law is relevant here—HMOs are within the proper scope of persons protected by the savings clause, *i.e.*, those subject to insurance regulation. If the New York law is held to impermissibly affect choices about coverage, therefore, it is nonetheless saved from preemption under the savings clause of the Act.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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